



State of Michigan Flexible Spending Account 2009 Plan Booklet



Flexible Spending Accounts Resource Directory

Company	Department	Hours	Phone/Web Address
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Automatic Data Processing (ADP) (Flexible Spending Accounts)	Solution Center	8 a.m.—8 p.m. EST Monday—Friday	Phone: Toll Free (800) 422-3703 TDD: Toll Free (800) 284-7904
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ADP Claims Processing P O Box 1853 Alpharetta, GA 30023-1853			Fax: Toll Free (866) 392-4090 or (678) 762-5900
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On-Line Account Information			Effective January 1, 2009 https://www.flexdirect.adp.com/mifsa/
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Health Care Debit Card	Lost or Stolen Card or Additional Card Request	24 Hours a Day	Phone: Toll Free (800) 422-3703
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Company	Department	Hours	Phone/Web Address
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State of Michigan	MI HR Service Center 400 South Pine Street P O Box 30002 Lansing, MI 48909	7 a.m.—6 p.m. EST Monday—Friday	Phone: Toll Free (877) 766-6447 (517) 335-0529 TDD: (517) 241-8046 Fax: (517) 241-5892 www.michigan.gov/selfserv
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Civil Service Commission Employee Benefits Division 400 South Pine Street P O Box 30002 Lansing, MI 48909	8 a.m.—5 p.m. EST Monday—Friday	Phone: Toll Free (800) 505-5011 (517) 373-7977 www.michigan.gov/employeebenefits Select 'Flexible Spending'
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Introduction to the Flexible Spending Account Plan

The State of Michigan is pleased to sponsor an employee benefit program known as The Flexible Spending Account Plan. There are two types of flexible spending accounts: a Health Care Spending Account (HCSA) and a Dependent Care Spending Account (DCSA).

The Plan is called a “flexible” spending account because you determine the amount of unreimbursed eligible medical and/or dependent day care expenses that you (and where applicable, your eligible family members) will likely incur during the plan year. You elect to have the State of Michigan withhold equal amounts from your pay (subject to Plan limitations) *on a pre-tax basis* for reimbursement of such expenses. Any amounts that you elect to have withheld for reimbursement of eligible medical expenses will be credited to the HCSA and any amounts that you elect to have withheld for reimbursement of dependent day care expenses will be credited to the DCSA. It is important that you carefully determine the amount you want to allocate to the Plan because any amounts that are not used for expenses incurred during the plan year and corresponding grace period will be forfeited.

The Plan is beneficial to you because amounts that you elect to have withheld from your pay for reimbursement of eligible medical and/or dependent day care expenses are withheld *before* any Federal income taxes, Social Security taxes (FICA), and Michigan state income taxes are applied. If you have unreimbursed medical and/or dependent day care expenses, participation in this Plan will actually increase your take-home pay over what your net take-home pay would be if you paid for such expenses with after-tax dollars.

This Plan Booklet is divided into five parts:

- Part I: General Information about the Plan
- Part II: HCSA Benefit
- Part III: DCSA Benefit
- Part IV: ADP Health Care Debit Card
- Part V: Annual Grace Period

This Plan Booklet describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. We encourage you to read the entire booklet, but if you have questions about the Plan, please refer to the Table of Contents to find the topic that most closely resembles your question.

Flexible Spending Account Plan

Part I: General Information

1. What is the purpose of a Flexible Spending Account (FSA)?

The purpose of an FSA is to allow eligible employees to use pre-tax dollars to pay for eligible, unreimbursed medical and/or dependent day care expenses.

2. Who can participate in the FSAs?

All State of Michigan employees except non-career and Special Personal Services (SPS) employees, can participate in FSAs. Employees who are hired as seasonal employees must ensure the number of deductions elected does not exceed the number of pay periods you expect to be employed during the year. Employees must notify the Employee Benefits Division at (800) 505-5011 or (517) 373-7977 upon leave from and return to pay status.

3. How do I become a participant?

- Carefully read this booklet and calculate your estimated expenses.
- During the enrollment period, you may call the ADP Participant Solution Center toll free at 1-800-422-3703, to determine what expenses are eligible. The ADP Participant Solution Center cannot assist with enrollment or with MI HR Self-Service questions.
- You can use the online calculators on the State of Michigan web site at www.michigan.gov/employeebenefits. Select 'Flexible Spending', then 'Tax Savings Calculators' to calculate your estimated tax savings.
- Enrollments must be entered using MI HR Self-Service at www.michigan.gov/selfserv.
- Access to MI HR Self-Service is available 7 days a week (via the Internet/Intranet), except during regularly scheduled maintenance. The maintenance schedule and password assistance are available on the MI HR Gateway at www.michigan.gov/selfserv. At the bottom of the page select 'System Availability' or 'Password Help'.
- When you have completed your online enrollment, you will immediately receive an electronic confirmation statement on the screen. We strongly recommend that you print and retain this confirmation statement. This is your only proof of successful enrollment.
- Please contact the MI HR Service Center at (877) 766-6447 (toll free) or at (517) 335-0529 if you do not have access to a computer or need assistance with MI HR Self-Service.
- **Your enrollment must be completed between November 3, 2008, and December 1, 2008.**

4. What are the enrollment periods under the Plan?

New Employees: If you wish to enroll in the FSAs you must contact the Employee Benefits Division at (800) 505-5011 or (517) 373-7977 within 30 days of your hire date. If you do not enroll during this initial eligibility period, you must wait until the next annual open enrollment or until you experience a valid life event change as described in question 9.

Current Employees: You must enroll during the annual open enrollment. The 2009 plan year open enrollment dates are November 3, 2008, through December 1, 2008, unless you have an eligible life event change as described in question 9.

If you are a current participant in the FSAs and you fail to enroll during the annual enrollment period, you will be deemed to have elected not to participate during the 2009 plan year.

5. How are the contributions to the spending accounts made under the Plan?

When you become a participant in the Plan, your contributions for the elected spending accounts will be paid with pre-tax contributions that you elected when you enrolled. Pre-tax contributions are amounts withheld from your gross income before any applicable Federal taxes, Social Security taxes (FICA), and Michigan state taxes have been applied.

6. What is my period of coverage?

Current Employees: Your period of coverage for incurring expenses is the full 2009 plan year January 1, 2009, through December 31, 2009, plus the corresponding grace period of January 1, 2010, through March 15, 2010.

New Employees: After completion of the benefits enrollment, coverage will be effective on the first day of the bi-weekly payroll period following either:

- Your first day of employment, or
- The date when the enrollment process is completed, whichever is later.

If you enroll during open enrollment, your period of coverage is the same as the plan year (January 1, 2009, through December 31, 2009), plus the corresponding grace period of January 1, 2010, through March 15, 2010.

Note: If you are no longer employed by the State of Michigan on the last day of the plan year, December 31, 2009, the grace period does not apply unless you have elected COBRA as described in question 24.

7. What is a split period of coverage?

For an HCSA, a mid-plan year election change due to a qualifying life event will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change, however, expenses incurred before the election change can only be reimbursed from the amount of the balance present in the HCSA prior to the change.

Split periods of coverage do not apply to DCSAs. If you are on a leave of absence, you will have a period of ineligibility while you are off.

8. What are the IRS special consistency rules governing life event changes?

- A change in your elected annual goal is permitted only if a valid life event occurs, as defined by the IRS and the requested change in the annual goal is consistent with the life event.
- *Loss of Dependent Eligibility* – If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to your divorce, your spouse's or dependent's death, or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
- *Gain of Coverage Eligibility Under Another Employer's Plan* – If you, your spouse, or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may stop or decrease that individual's coverage if that individual gains coverage, or has coverage increased under the other employer's plan.
- *Dependent Care Expenses* – You may change or terminate your DCSA election when a life event change affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.

9. Can I ever change my election during the plan year?

You cannot change your election to participate in the Plan or vary the pre-tax contribution that you have elected to allocate to the HCSA and/or the DCSA unless you have a qualifying life event. Your election to participate in the Plan will automatically terminate if you cease to satisfy the applicable eligibility requirements. Otherwise, you may change your pre-tax contribution elections during the annual enrollment period, and then, only for the next plan year.

There is an important exception to this general rule. You may change or revoke your elections or join the plan during the plan year within 30 days of experiencing one of the following events. Note that not all of the events apply to HCSA elections.

A. **Life Event Change.** If one or more of the following life event changes occur, you may revoke your old election and make a new election:

- A change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse).
- A change in the number of your tax dependents (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent).
- Any of the following events that change the employment status of you, your spouse, or your dependent and that affect benefit eligibility under this Plan or other employee benefit plans. Some events include: termination or commencement of employment, change from part-time to full-time employment, incurring a reduction or increase in hours of employment, or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit.
- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, or ceasing to be a student).

The election change must be based solely on and correspond with the life event change. With the exception of an election change to the HCSA resulting from birth, placement for adoption or adoption, all election changes are prospective. As a general rule, a desired election change will be found to be consistent with a life event change if the event affects eligibility for coverage under the Plan. A life event change affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the Plan. In addition, you must also satisfy the following specific IRS requirements in order to alter your election based on that life event change:

Gain of Coverage Eligibility Under Another Employer's Plan. For a life event change in which you, your spouse, or your dependent gain eligibility for coverage under another employer's cafeteria plan (or benefit plan) as a result of a change in your marital status or a change in your, your spouse's, or your dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that life event change *only* if coverage for that individual becomes effective or is increased under the other employer's plan. You may be required to provide proof that coverage will become effective.

Dependent Care Reimbursement Plan Benefit. With respect to the Dependent Care Reimbursement Plan benefit, you may change or terminate your election only if (1) the change or termination is made solely on the basis of and directly corresponding with a life event change that affects eligibility for coverage under the Plan; *or* (2) your election change is based solely on and corresponds with a life event change that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. Mike elects to reduce his salary by \$2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a life event change. Mike's election to cancel coverage under the dependent care program would be consistent with this life event change.

- B. Special Enrollment Rights** (This applies to HCSA elections only.) If you declined enrollment in medical coverage for yourself or your eligible dependents because of outside medical coverage and coverage is lost due to certain reasons (e.g., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect HCSA coverage for yourself and your eligible dependents who lost coverage. Furthermore, if you have a new dependent as a result of marriage, birth, or adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within the 30 day election change period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days.
- C. Certain Judgments, Decrees and Orders.** If a judgment, decree, or order from a divorce, legal separation, annulment, or custody change requires your dependent child (including a foster child who is your tax dependent) to be covered under this Plan, you may change your election to provide coverage for the dependent child identified in the order. If the order requires that another individual (such as your former spouse) cover the dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the dependent child.
- D. Entitlement to Medicare or Medicaid.** If you, your spouse, or a dependent becomes entitled to Medicare or Medicaid, you may modify or cancel HCSA coverage. Similarly, if you, your spouse, or a dependent had been entitled to Medicare or Medicaid and lose eligibility, you may elect to begin or increase that person's HCSA coverage.
- E. Change in Cost** (This applies only to DCSA elections.) If your dependent care cost has *significantly* increased or decreased, you may make certain prospective election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and choose another day care provider, or drop coverage altogether if you are unable to find another provider. If the cost significantly decreases, you may revoke your election and make a new election to correspond with the decrease in cost. The Plan Administrator for the State of Michigan (Employee Benefits Division) will have final authority to determine whether the requirements of this section are met.
- F. Change in Coverage** (This applies only to DCSA elections.) If your need for coverage under the DCSA has *significantly* decreased, you may revoke your election and either choose another day care provider or drop coverage altogether. In addition, if you change day care providers, you may revise your elections to correspond to the new provider. Also, you may make an election change that is solely based upon and corresponding with a change made under another employer plan (including a plan of the State of Michigan or another employer), provided: (i) the other employer plan allows its participants to make an election change permitted under the IRS regulations, or (ii) the plan year for this Plan is different from the plan year of the other employer plan.
- G. Approved Leave of Absence.** If you are granted an approved leave of absence, your elections are subject to the following terms (depending, in part, on the type of leave you take):
- The State of Michigan will continue your HCSA coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay all missed contributions.
 - If you are returning from an unpaid FMLA leave, you will be permitted to restart the DCSA upon your return from leave in the same calendar year on the same basis as prior to the leave. Dependent care expenses that you incur while you are on a leave will not be reimbursed.
- H. Separation, Retirement or Layoff.** Different rules apply to the HCSA and the DCSA for separation, retirement, or layoff, so please see the specific sections of this plan booklet that apply to these circumstances.

10. How will Plan participation impact Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

11. What is the timeframe for making changes to my accounts based on qualifying life event changes?

You can change your FSA election(s) or vary the salary reduction amounts you have selected during the plan year only under limited circumstances as specified in IRS guidelines. Partial lists of permitted qualifying events under your employer's plan(s) appear on the previous pages. *Election changes must be consistent with the event.*

Within **30 days** of an event that is consistent with one of the events on the previous pages, you may stop or modify your FSA by contacting the Employee Benefits Division at (800) 505-5011 or (517) 373-7977. You will be required to provide appropriate documentation substantiating the life event.

Mid-year plan election changes can only be made prospectively and will be effective the first payroll after your election change request has been processed unless it is a change to the HCSA resulting from a birth or adoption. If your FSA election change request is denied, you will have **28 calendar days**, from the date the denial is issued, to file an appeal with the Employee Benefits Division.

Flexible Spending Account Plan

Part II: Health Care Spending Account (HCSA) Benefit

The following Questions and Answers relate to the HCSA benefit.

12. What is the Health Care Spending Account (HCSA)?

The Health Care Spending Account (HCSA) is the portion of the Plan that provides for reimbursement of eligible medical expenses incurred by the participant and his/her eligible dependents. An HCSA can save you money on eligible out-of-pocket health care expenses, such as doctor office co-pays, dental and medically needed orthodontia co-pays, prescription co-pays, health insurance deductibles, vision expenses not covered by insurance, and some over-the-counter drugs such as cold and allergy medications, pain relievers and antacids.

13. What is the maximum and minimum annual reimbursement amount that I may elect under the HCSA?

Each state employee may choose any reimbursement amount, subject to the minimum and maximum annual amounts listed below.

Minimum annual deposit:	\$2
Maximum annual deposit:	\$5,000 per employee

This means that a married couple may contribute up to \$10,000 annually (\$5,000 each) if both are employed by the State of Michigan.

14. How are amounts allocated to the HCSA withheld from my pay?

When you enroll, you specify the amount of bi-weekly pre-tax contribution and also indicate the number of pay periods (1-26) that you wish the contribution to be deducted from your pay.

15. What amounts will be available for reimbursement of eligible medical expenses at any particular time during the plan year?

Once you sign up for an HCSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

16. How do I receive reimbursement under the HCSA?

When you incur an eligible medical expense, you may file a claim with ADP by completing and submitting a Health Care Spending Account Claim Form. You can obtain a Health Care Spending Account Claim Form from ADP or by downloading the form online at www.michigan.gov/employeebenefits. Select 'Forms' from the left menu. You must include a statement from the service provider (e.g., a receipt or explanation of benefits from your insurance carrier, etc.) associated with each expense, that indicates the following:

- The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug.

- The date the expense was incurred.
- The amount of the expense.

You may be required to provide additional substantiation to support your claim. ADP will process the claim once it receives the Health Care Spending Account Claim Form from you. Reimbursement for expenses that are determined to be eligible medical expenses will be made within 5 business days after receiving and processing the claim. If the expense is determined not to be an “eligible medical expense” you will receive notification of this determination. You must submit all claims for reimbursement for eligible medical expenses by April 15, 2010.

You may also use an ADP Health Care Debit Card to pay expenses at the time they are incurred. The terms of the electronic payment card are located on pages 21 to 23 in this booklet.

17. What is an “eligible medical expense”?

An “eligible medical expense” is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

- The expense is for “medical care” as defined by IRS Code Section 213(d).
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

An “eligible dependent” is your legal spouse (in accordance with federal law) and any other individual who is a “dependent” as defined in IRS Code Section 105(b). Coverage for an individual covered as an eligible dependent under the HCSA ends on the date that the individual ceases to meet the requirements to be an eligible dependent.

The IRS Code generally defines “medical care” as any amounts incurred to diagnose, treat or prevent a specific medical condition, or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription drugs and over-the-counter drugs, products, and devices. Not every health-related expense you or your eligible dependents incur constitutes an expense for “medical care”. For example, an expense is not for “medical care”, if it is merely for the beneficial health of you and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Also, “stockpiling” of over-the-counter drugs and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the plan year.

In addition, certain expenses that might otherwise constitute “medical care” as defined by the IRS Code are not reimbursable under any HCSA (per IRS regulations). These are:

- Health insurance premiums.
- Expenses incurred for qualified long term care services.

18. Are travel expenses related to my health care reimbursable?

Yes, if the service provided is medically necessary for vision, dental, or medical care, then travel to and from the healthcare provider to obtain service is reimbursable. Submit travel expenses when you are claiming reimbursement for the provided service.

Mileage

Mileage may be reimbursed at a rate of \$0.27 per mile (amount per mile reimbursable per IRS as of 7/1/08) for trips to and from your healthcare provider. A visit to your pharmacy will be treated as a visit to your local healthcare provider.

Parking fees and tolls

You may seek reimbursement for parking fees and tolls to your medical appointment. To substantiate the claim, you will need to provide a receipt for the toll and/or parking fee in addition to a bill or receipt from your healthcare provider.

Expenses incurred for out-of-town healthcare services, i.e., airline fare, hotel room and rental car

You may be reimbursed for the amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. You cannot be reimbursed for a trip or vacation taken merely for a change in environment, improvement of morale, or a general improvement of health, even if you make a trip on the advice of a doctor.

Lodging expenses incurred during my dependent's out-of-town hospitalization

You may be reimbursed for the cost of lodging not provided in a hospital or similar institution. The amount you include in medical expenses for lodging cannot be more than \$50 per night for each person.

Lodging is reimbursable for a person for whom transportation expenses are a medical expense because that person is traveling with the dependent receiving medical care. For example, if a parent is traveling with a sick child, up to \$100 per night can be reimbursed as a medical expense for lodging for both. Meals are not included.

You may calculate the mileage on the actual bill/invoice for medical care that resulted in your mileage claim. Include:

- Roundtrip mileage multiplied by \$0.27.
- The name of the provider visited.

Example: If your office visit with Dr. Jay on 7/1/09 resulted in a total of 80 miles roundtrip, your note should read: 7/1/09—80 miles x \$0.27 = \$21.60. Enter \$21.60 as the amount requested for reimbursement on your claim form, along with any other expenses associated with your travel (e.g., parking, tolls). To validate your visit, attach your statement, bill or invoice from your health care provider to your request.

19. When must the expenses be incurred in order to receive reimbursement?

Eligible medical expenses must be incurred *during* the plan year and while you are a participant, and/or during the grace period immediately following the plan year. An expense is incurred when the service or treatment has been performed and not in advance of the service. You may not be reimbursed for any expenses arising before your HCSA becomes effective, or after a separation from service (except for expenses incurred during an applicable COBRA continuation period). The only allowable exception to this rule is pre-payment of an orthodontic contract in order to receive a discount to the contract amount.

You can also use money in your 2008 account that is unused after December 31, 2008, for expenses incurred during the grace period, January 1, 2009, through March 15, 2009, if you are not on an unpaid leave or are no longer employed by the State of Michigan on December 31, 2008, and have not elected COBRA as described in question 27.

20. What if the eligible medical expenses I incur during the plan year and corresponding grace period are less than the annual amount I have allocated to the HCSA?

You will not be entitled to receive any payment of any amount that represents the difference between the actual eligible medical expenses you have incurred and the annual reimbursement amount that you have elected. Any money remaining in your HCSA will be forfeited if it has not been applied to reimburse expenses incurred during the plan year, and the grace period, January 1, 2010, through March 15, 2010. The run-out period is the time period after the plan year ends when you may continue to submit claims for reimbursement. The run-out period is from January 1, 2010, through April 15, 2010.

Exception: The “Heroes Earnings Assistance and Relief Tax Act of 2008” (H.R. 6081) was signed into law on June 17, 2008. Under this law, individuals called up from the reserves to active military duty for a period of at least six months would be allowed to receive a taxable distribution of their HCSA funds and would not be subject to forfeiture of unused funds. This law is considered an optional enhancement to the HCSA plans. The State of Michigan has adopted this enhancement to the plan.

21. What happens if a claim for benefits under the HCSA is denied?

If you are denied a benefit under this Plan, you should proceed in accordance with the following claims review procedures:

Step 1: *Notice is received from ADP.* If your claim is denied, you will receive written notice from ADP no later than 30 days after receipt of the claim. For reasons beyond the control of ADP, they may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which ADP must make a decision will be suspended until you provide the information, or until the end of the 45-day period, whichever comes first.

Step 2: *Review your notice from ADP carefully.* The notice will include:

- The reason(s) for the denial and the Plan provisions on which the denial is based.
- A description of any additional information necessary to process your claim, why the information is necessary, and your time limit for submitting the information.
- A description of the Plan’s appeal procedures and the time limits applicable to such procedures.
- A right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision from ADP.* You may file a written appeal with ADP no later than 180 days after receipt of the denial notice.

- You should submit all information identified in the notice of denial as necessary to process your claim and any additional information that you believe would support your claim.
- Notice of Denial is received from claims reviewer. If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by ADP.
- Review your notice carefully. You should take the same action that you take in Step 2 described above. The notice will include the same type of information that is provided in the first notice of denial provided by ADP.

Step 4: *If you still disagree with ADP’s decision.* You may file a written appeal with the Plan Administrator (Employee Benefits Division) within 28 calendar days from the date the first level appeal denial notice is issued from ADP. You should gather any additional information that is identified in the notice as necessary to process your claim, and submit other information that you believe would support your claim.

You may send your 2nd level appeal to:

Civil Service Commission
Director, Employee Benefits Division
400 S Pine Street
P O Box 30002
Lansing, MI 48909

22. What happens to unclaimed HCSA reimbursements?

Any reimbursements under the HCSA that are unclaimed (e.g., uncashed benefit checks) by the close of the plan year following the plan year in which the eligible medical expense was incurred shall be forfeited.

23. What is continuation of HCSA coverage under COBRA?

Federal law requires that the State of Michigan Health Care Flexible Spending Account (HCSA) give employees and their families the opportunity to continue their coverage when there is a “qualifying event” that would result in a loss of coverage. “Qualified beneficiaries” can include the employee covered under the plan, a covered employee’s spouse, and dependent children of the covered employee.

Each qualified beneficiary who elects continuation of coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights.

24. What happens to my HCSA if I retire, separate from state service, or experience a layoff?

If you are planning for any of these events to occur during the calendar year, you may sign up for your annual deduction to be spread over available pay periods. If any of these unplanned events occur during the calendar year, you must contact the MI HR Service Center at least **two weeks** prior to your last day of work or as soon as possible if the event was unpredictable.

If you retire, separate from state service, or experience a layoff and elect COBRA, there are two options for payment of your deduction amount:

- You can arrange to have the balance of your deductions taken from your last paycheck by contacting the Employee Benefits Division at (800) 505-5011 or (517) 373-7977. The deduction will be taken from pre-tax dollars, or
- You can arrange to pay the balance of the deductions with post-tax dollars by contacting the Employee Benefits Division within 60 days of the last day worked.

If you are a seasonal employee who enrolled during open enrollment, and are laid off as of January 1, 2009, your HCSA and debit card will be inactivated until you return to work and contact the Employee Benefits Division at (800) 505-5011 or (517) 373-7977 to restart your account.

25. What happens to my HCSA if I go on an unpaid leave of absence or experience lost time?

If you go on an unpaid leave of absence or experience lost time, your HCSA and debit card will remain available for you to use while you are off.

You will be required to make up all of your missed contributions when you return to work. The Employee Benefits Division will recalculate and restart your bi-weekly contributions for the remaining pay periods in the year, at an amount that will make up your missed contributions from the remaining pay periods in the year. If you return to work after the end of the plan year, or if there are not enough pay periods remaining in the plan year to make up your missed contributions, the State of Michigan will collect the remaining amount due from your pay warrant on a post-tax basis.

Special Circumstance: The “Heroes Earnings Assistance and Relief Tax Act of 2008” (H.R. 6081) was signed into law on June 17, 2008. Under this law, individuals called up from the reserves to active military duty for a period of at least six months would be allowed to receive a taxable distribution of their HCSA funds and would not be subject to forfeiture of unused funds. This law is considered an optional enhancement to the HCSA plans. The State of

Michigan has adopted this enhancement to the plan.

26. How long will continuation of HCSA coverage under COBRA last?

You may continue your HCSA (post-tax) only for the remainder of the plan year in which your qualifying event occurs, if you have not already used your full HCSA enrollment amount. For example, if you elected a maximum HCSA benefit of \$1,000 for the plan year and have received only \$200 in reimbursement, you may continue your HCSA for the remainder of the plan year and corresponding grace period only by electing COBRA and making all contributions as described in question 28.

27. How much does continuation of HCSA coverage under COBRA cost?

The cost for continuation of coverage is a monthly amount calculated and based on the amount you were contributing via pre-tax salary deductions before the qualifying event.

28. When and how must payments for continuation of HCSA coverage under COBRA be made?

First Payment for Continuation of HCSA Coverage under COBRA

You must make your first payment for continuation of coverage within 45 days after the date of your election. If you do not make your first payment for continuation of coverage within that 45 day period, you will lose all continuation of coverage rights under the Plan.

Your first payment must cover the cost of continuation of coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You may contact the Employee Benefits Division at (800) 505-5011 or (517) 373-7977 to confirm the correct amount of your first payment and to obtain instructions for sending your first payment for continuation of coverage.

Periodic Payments for Continuation of HCSA Coverage under COBRA

After you make your first payment for continuation of coverage, you will be required to pay in advance for continuation of coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation of coverage are due on the **fifteenth day of the month prior to coverage**.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment.

Your continuation of coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation of coverage under the Plan.

Flexible Spending Account Plan

Part III: Dependent Care Spending Account (DCSA) Benefit

The following Questions and Answers relate to the DCSA benefit.

29. What is the Dependent Care Spending Account (DCSA)?

A Dependent Care Spending Account can be used to pay for day care expenses while you or your spouse are at work, looking for work, or are at school. It can also be used for local day camp and for care expenses for any incapacitated person you are eligible to claim on your income taxes. The Dependent Care Spending Account may not be used for medical expenses.

30. What are the maximum and minimum reimbursement amounts that I may elect under the DCSA?

Maximum Family Statutory Limit

- If you are married and filing separately, your maximum annual deposit is \$2,500.
- If you are single and head of household, your maximum annual deposit is \$5,000.
- If you are married and filing jointly, your maximum annual deposit is \$5,000.
- If either you or your spouse earn less than \$5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

Please Note: These limits apply to the total allowable non-taxable amount for DCSA during one calendar year. If you use more than your family's maximum annual statutory limit in one calendar year due to expenses paid during a previous plan year's grace period and current plan year elections, you will be responsible for reporting and paying Federal and State income taxes on any amount above your statutory limit. Please see Question 41 for further information.

Minimum

The minimum annual deposit is \$2 bi-weekly.

31. How are amounts allocated to the DCSA withheld from my pay?

When you enroll, you specify the dollar amount of your bi-weekly pre-tax contribution and the number of pay periods (1-26) from which contributions will be deducted from your pay.

32. When can I receive reimbursement for eligible day care expenses?

Once you sign up for a DCSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike an HCSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

33. How do I receive reimbursement under the DCSA?

When you incur an eligible day care expense, file a claim with ADP by completing and submitting a Dependent Care Spending Account Claim Form. You may obtain a Dependent Care Spending Account Claim Form from ADP or by downloading the form on-line at www.michigan.gov/employeebenefits. Select 'Forms' from the left menu. You must include with your Dependent Care Spending Account Claim Form a written statement from the service provider (e.g., an invoice) associated with each expense that indicates the following:

- The nature of the expense.
- The date or dates the services were provided.
- The amount of the expense.

You do not need to supply ADP the taxpayer identification number for your dependent care service provider on the DCSA claim form.

ADP will process the claim once it receives the Dependent Care Spending Account Claim Form from you. Reimbursement for expenses that are determined to be eligible day care expenses will be made within 5 business days after receiving and processing the claim. If the expense is determined not to be an "eligible day care expense" you will receive notification of this determination. You must submit all claims for reimbursement for eligible day care expenses prior to the end of the run-out period, April 15, 2010.

34. What are "eligible day care expenses"?

You may be reimbursed for work-related dependent day care expenses ("eligible day care expenses"). In other words, the expenses have to be incurred in order for you and your spouse (if applicable) to work or look for work. Generally, an expense must meet all of the following conditions for it to be an eligible day care expense:

1. The expense is incurred for services rendered after the beginning of the plan year for DCSA reimbursement benefits and during the calendar year and grace period to which it applies.
2. Each individual for whom you incur the expense is a "qualifying individual". A "qualifying individual" is:
 - An individual age 12 or under who (a) lives with you; (b) does not provide over half of his/her own support; and (c) is your "child" (son, daughter, grandchild, step child, brother, sister, niece and nephew), or
 - A spouse (as defined for purposes of federal law) or other tax dependent (as defined in IRS Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year.

Note: There is a special rule for children of divorced parents. If you are divorced, the child is only a qualifying individual of the "custodial" parent (as defined in IRS Code Section 152(e)).

3. The expense is incurred for the care of a qualifying individual (as described above), or for related household services, and is incurred to enable you to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible.
4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a "qualifying individual" who is age 13 or older, such dependent regularly spends at least 8 hours per day in your home.
5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility) and the center complies with all applicable state and local laws and regulations.

6. The expense is not paid or payable to a “child” (as defined in IRS Code Section 152(f)(1)) of yours who is under age 19 the entire year in which the expense is incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.
7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441. You do not need to supply ADP the taxpayer identification number for your dependent care service provider on the DCSA claim form.

35. What happens to my DCSA if I retire, separate from state service, or experience a layoff?

Your eligibility for the DCSA ends on your last day of work for the State of Michigan even if you contribute to the plan after this date. Therefore, any expenses incurred after your last day worked for the State of Michigan will not be eligible for reimbursement, even if you have a balance remaining in your account. If you are planning for any of these events to occur during the calendar year, please plan your contributions accordingly.

36. What happens to my DCSA if I go on an unpaid leave of absence or experience lost time?

- Your eligibility for the DCSA will end on your last day of work.
- When you return to work your contributions will restart at the same bi-weekly amount you designated unless you contact the Employee Benefits Division and request a change due to a life event. Please see question 9 in this booklet, “Can I ever change my election during the plan year?”.
- You will have a period of ineligibility beginning the first day after your last day worked and ending the first day of the pay period in which your contributions restart.

37. When must DCSA expenses be incurred in order to receive reimbursement?

Eligible day care expenses must be incurred *during* the plan year and/or during the corresponding grace period in which you are a participant. An expense is “incurred” when the service has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the DCSA becomes effective, or after a separation from service, *even if you contribute to the plan after your date of separation*.

38. What if the eligible day care expenses I incur during the plan year are less than the annual amount I have allocated to the DCSA?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual eligible day care expenses you have incurred and the annual reimbursement amount that you have elected. Any amount allocated to the DCSA shall be forfeited by the participant if it has not been applied by the end of the run-out period to reimburse expenses incurred during the plan year and corresponding grace period. The run-out period is the time period after the plan year ends when you may continue to submit claims for reimbursement. The run-out period is from January 1, 2010, through April 15, 2010. Amounts forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations.

39. What happens if a claim for benefits under the DCSA is denied?

If you are denied a benefit under this Plan, you should proceed in accordance with the following claims review procedures:

Step 1: Notice is received from ADP. If your claim is denied, you will receive written notice from ADP no later than 30 days after receipt of the claim. For reasons beyond the control of ADP, they may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party

Administrator must make a decision will be suspended until you provide the information, or until the end of the 45-day period, whichever comes first.

Step 2: *Review your notice from ADP carefully.* The notice will include:

- The reason(s) for the denial and the Plan provisions upon which the denial is based.
- A description of any additional information necessary to process your claim, why the information is necessary, and your time limit for submitting the information.
- A description of the Plan's appeal procedures and the time limits applicable to such procedures.
- A right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision from ADP.* You may file a written appeal with ADP no later than 180 days after receipt of the notice described in Step 1.

- You should submit all information identified in the notice of denial as necessary to process your claim and any additional information that you believe would support your claim.
- Notice of denial is received from claims reviewer. If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by ADP.
- Review your notice carefully. You should take the same action that you take in Step 2 described above. The notice will include the same type of information that is provided in the first notice of denial provided by ADP.

Step 4: *If you still disagree with ADP's decision.* You may file a written appeal with the Plan Administrator (Employee Benefits Division) within 28 calendar days from the date the first level appeal denial notice is issued from ADP. You should gather any additional information that is identified in the notice as necessary to process your claim, and any other information that you believe would support your claim. You may send your 2nd level appeal to:

Civil Service Commission
Director, Employee Benefits Division
400 S Pine Street
P O Box 30002
Lansing, MI 48909

40. What happens to unclaimed DCSA reimbursements?

Any DCSA reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the plan year following the plan year in which the eligible day care expense was incurred shall be forfeited.

41. Will I be taxed on the DCSA reimbursement I receive?

You will not normally be taxed on your DCSA reimbursement, provided that your family's aggregate dependent day care reimbursement (under this DCSA and/or another employer's DCSA) does not exceed the statutory limits set forth on page 17. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

42. If I participate in the DCSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this DCSA, although the balance of your eligible day care expenses not reimbursed under this DCSA may be eligible for the dependent care credit.

Flexible Spending Account Plan

Part IV: ADP Health Care Debit Card

The State of Michigan permits participants to use the ADP Health Care Debit Card to pay for eligible expenses at the point of service. The following rules apply:

ADP Health Care Debit Card Terms of Usage

You may use the card to pay for Health Care Spending Account (HCSA) expenses.

You have two reimbursement options for the HCSA. You can complete and submit a written claim for reimbursement (“Traditional Paper Claims”) as indicated in question 16, ‘How do I receive reimbursement under the HCSA?’ Alternatively, you may use the debit card to pay the expense. The following is a summary of how the Health Care Debit Card works:

ADP Health Care Debit Card. The debit card allows you to pay for eligible expenses at the time that you incur the expense. Here is how the debit card works:

- a. *You must make an election to use the card.* In order to be eligible for the debit card, you must agree to abide by the terms and conditions of the Plan as set forth herein and in the Cardholder Agreement including limitations as to card usage, the Plan’s right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Plan during each open enrollment period and when you activate your card. A Cardholder Agreement will be provided to you with your debit card. The card will be turned off effective the first day of each plan year if you do not enroll during the preceding open enrollment period. When you activate your card, the Cardholder Agreement becomes a part of the terms and conditions of your Plan.
- b. *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation of coverage period.
- c. *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify during open enrollment that the amounts in your reimbursement account will only be used for eligible expenses and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.
- d. *Reimbursement under the card is limited to certain specific providers (including pharmacies).* Use of the card for HCSA reimbursement is limited to merchants who are health care providers (doctors, participating pharmacies, etc.) Your card may not be accepted within general merchandise stores and pharmacies that have not installed an Inventory Identification Approval System (IIAS) as required by the IRS.
- e. *When you incur an eligible expense, you swipe the card at the provider like you would a typical credit or debit card.* The provider is paid for the expense up to the maximum reimbursement amount at that time you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment is being made is an eligible expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

- f. *If you are enrolled in the HCSA and you are not the primary insured* on one of the State of Michigan employee health insurance plans, or if you are covered by a health insurance plan through a different employer, you will be required to substantiate most or all of your debit card transactions. This will also happen if you and your spouse both work for the State of Michigan but you are carried on your spouse's insurance plan.
- g. *You must obtain and retain documentation (e.g., receipt, invoice, etc.) of the expense from your medical provider each time you swipe the card.* The documentation must include the following information:
- The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for a drug or an over-the-counter item, the written statement must indicate the name of the drug or item.
 - The date(s) the expense was incurred.
 - The amount of the expense.

You must retain this documentation for one year following the close of the plan year in which the expense is incurred. Even though payment is made under the card arrangement, written documentation is required to be retained for a minimum of one year subsequent to the end of the plan year. If you receive a letter from ADP requesting documentation, you must provide the documentation to ADP within the timeframe indicated on the request. You do not need to submit this documentation to ADP unless you are notified by ADP to do so.

- h. *There are situations under the HCSA where documentation will not be required to be provided to ADP.* More detail as to which situations apply under your Plan is specified in the Cardholder Agreement:

Co-Pay Match: As specified in the Cardholder Agreement, if the ADP Health Care Debit Card payment matches a specific co-payment you have under the component medical plan, for the particular service that was provided, you may not be required to submit substantiating documentation. For example, if you have a \$15 co-pay for physician office visits, and the payment was made to a physician office in the amount of \$15, you may not be required to provide the third party statement to ADP. If you do not participate in the State of Michigan's employee medical plans, automatic adjudication is not possible for co-payments. This is also true if both spouses are state employees and one carries the health insurance, but the other carries the FSA.

Provider Match Program: As specified in the Cardholder Agreement, no documentation may be required to be submitted to ADP if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g., your prescription benefit manager) that identifies the nature of your expense and verifies the amount.

Note: The IRS requires you to obtain and keep for one year the substantiating documentation from your medical provider or pharmacy when you incur the expense and swipe the card, even if you think it will not be needed.

- i. *You must repay the Plan for any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by ADP, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible expenses. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement and in Michigan Civil Service Regulation 5.20) or the remaining unpaid amount may result in additional gross income reflected in a W-2C form.
- j. *You can use either the payment card or the traditional paper claims approach to submit your eligible claims.* If you elect not to use the Health Care Debit Card, you may also submit claims under the traditional paper claims approach. Claims for which the ADP Health Care Debit Card has been used cannot be submitted as traditional paper claims.

The Debit Card and Grace Period

If you have money left in your 2009 FSA account after December 31, 2009, you may incur claims from January 1, 2010, through March 15, 2010, pay for the expense, and submit an ADP Health Care Spending Account Claim Form to ADP. Your claim(s) will be paid from your 2010 account, and the appropriate amount of money will be transferred from your 2009 account into your 2010 account on a weekly basis for claims incurred prior to March 15, 2010, and submitted through April 15, 2010.

If you have expenses that you incurred during 2009 and want them to be reimbursed from your 2009 contributions, it is important that you submit them prior to using your debit card or submitting expenses you incur during 2010. In other words, **it is important you submit claims in the order in which they were incurred.**

You can use your ADP Health Care Debit Card after December 31, 2009, if you have money left in your 2009 account only if you are also enrolled in the 2010 HCSA. After December 31, 2009, if you have money remaining in your 2009 account you may pay for the eligible expense with your debit card if you are enrolled during 2010. Your expense will be paid from your 2010 account balance and the correct amount from your 2009 account will be replaced into your 2010 account on a weekly basis for claims incurred prior to March 15, 2010, and submitted through April 15, 2010.

Flexible Spending Account Plan

Part V: Annual Grace Period

The State of Michigan has established a “grace period” that follows the plan year ending December 31, 2009. The grace period permits you to be reimbursed for eligible medical expenses and/or dependent care expenses incurred during the 2009 plan year, as well as those incurred during the grace period. The grace period will begin on January 1, 2010, and end on March 15, 2010.

In order to take advantage of the grace period, you must be:

- A participant in the Health Care Spending Account (HCSA) and/or the Dependent Care Spending Account (DCSA) and not on an unpaid leave or separated from state service, on the last day of the plan year to which the grace period relates, or
- A qualified beneficiary who is receiving COBRA coverage under the HCSA on the last day of the plan year to which the grace period relates.

Please submit claims for all services incurred during 2009 prior to using your debit card in 2010 or to submitting claims for services incurred during 2010.

If you still have money left in your 2009 account after December 31, 2009, you may incur claims from January 1, 2010, through March 15, 2010, pay for the expense and submit an ADP Health Care Spending Account Claim Form to ADP. Your claim(s) will be paid from your 2010 account, then once per week for claims incurred prior to March 15, 2010, and submitted by April 15, 2010, the appropriate amount of money will be transferred from your 2009 account into your 2010 account.

If you have expenses that you incurred during 2009 and want them to be reimbursed from your 2009 contributions, it is important that you submit them prior to using your debit card or submitting expenses you incur during 2010. In other words, **it is important you submit claims in the order in which they were incurred.**

IMPORTANT: Any unused amounts in your Plan that are not used to reimburse eligible expenses incurred in the plan year and/or in the corresponding grace period will be forfeited if they are not submitted for reimbursement before the end of the run-out period, **April 15, 2010.**

Exception: The “Heroes Earnings Assistance and Relief Tax Act of 2008” (H.R. 6081) was signed into law on June 17, 2008. Under this law, individuals called up from the reserves to active military duty for a period of at least six months would be allowed to receive a taxable distribution of their HCSA funds and would not be subject to forfeiture of unused funds. This law is considered an optional enhancement to the HCSA plans. The State of Michigan has adopted this enhancement of the plan.

Grace Period Examples for 2009 Plan Participants (January 1, 2010, through March 15, 2010)

Example 1: You have \$200 remaining in your 2009 Health Care or Dependent Care Spending Account. You enrolled for \$1,000 for the 2010 plan year. You incur a \$300 eligible expense on 1/20/10. You pay for the service and submit an ADP Health Care Spending Account Claim Form to ADP. ADP will reimburse you \$300 of the claim from your 2010 account. ADP will replenish your 2010 account with the \$200 remaining in your 2009 account.

If you have expenses that you incurred during 2009 and want them to be reimbursed from your 2009 contributions, it is important that you submit them prior to using your debit card or submitting expenses you incur during 2010. In other words, **it is important you submit claims in the order in which they were incurred.**

Example 2: You have a balance in your 2009 Health Care or Dependent Care Spending Account and are not enrolled in the Flexible Spending Accounts in 2010. You will be able to incur eligible expenses through March 15, 2010. You must pay for those expenses and then submit the ADP Health Care Spending Account Claim Form with the necessary required documentation to ADP by April 15, 2010.* You will then be reimbursed for those expenses up to the balance(s) remaining in your 2009 account(s).

*Please note that if you are enrolled in the 2009 HCSA, but do not enroll in the HCSA for 2010, your Health Care Debit Card will be turned off December 31, 2009.